LETTERS *to the Editor*

More Physicians Through Perimeter Personnel Training

To the Editor: The editorial, "Medical Education in Transformation,"[1] inviting practicing physicians to participate, strikes a positive response. The areas in greatest need of medical care provision in which demand for services far outstrip the mechanics for production of medical manpower and facilities are the low economic and more remote geographic perimeter areas. The paraphrased adage, "a patient, an interested student, and an experienced doctor," names the essentials of fundamental medical education. Buildings, libraries, laboratories, and research programs are adjuncts in refinement for scientific advancement. Basic sciences and their application to medicine are the result of the efforts of doctors under duress who have utilized scientific method to construct fundamental developments in medicine.

People in isolated geographic or low income economic areas merit particular effort. This is an ideal locus for the development of multiphasic medical education-service projects. Physicians experienced in practice, young aspirants desirous of training for a medical professional career and medical educators may be coordinated for mutual advantage in medical care provision.

Improved services for patients in perimeter areas may be developed by and within the structure for a low cost service project, utilizing volunteers from the large body of undirected, bewildered, pre-medical school students who are rejected by the 108 medical schools in the United States. This group has increased from approximately 10,000 to 14,000 annually during the last five years. According to Nicholson,[2] over 53 percent of the 26,000 total applicants this year were "non-accepted." The development of well planned training projects pointed toward challenging volunteers from this group to assist in the solution of the medical manpower crisis should be feasible in some measure in almost every area.

Recent JAMA articles and two editorials,[2,3,4] deal with efforts of American students and to problems and the poor yield resulting from foreign medical school attendance.[5]

Continuing discussions at AMA, AAMC, and World Medical Association Assembly levels attest the need for action in this field by medicine and the seriously thoughtful public.

Admittedly, the non-accepted pre-medical students have lower grade-point and aptitude test averages than do the students admitted to medical schools. However, they are well above the college and university average and they have a demonstrable motivation for medicine.

The project proposed here for utilizing volunteers from this large reservoir of students offers an alternate route for the usual first academic year. This proposal combines two three-month concentrated training periods in the academic center separated by a nine-month supervised exposure to practical clinical experience at the community level. It goes like this: Early in the summer after non-acceptance, the volunteers would be screened by an interview team of an academic faculty member and an experienced clinician. This would be followed by a three-month orientation and technical training course comparable to that of the military medical corpsmen training. This should prepare the volunteer for the nine-month clinical experience as a "basic physician's assistant" actively contributing to patient care in areas of demonstrated medical service need under physician supervision. A second and final three-month clinically oriented biophysiological training in the medical center should be followed by comprehensive oral and written examinations.

Such a program should prepare the student and provide the faculty with a sufficient base for the selection of candidates from this group to be enrolled into the second year medical school class. Those students who have demonstrated less aptitude should be directed toward training as an "advanced physician's assistant" or accepting one of the medical technological traineeships.

To encourage "upward mobility" and "the ability to achieve" in this group, it should be emphasized that after one or more years in the supporting career role, candidates may again apply for re-examination for medical school matriculation.

This project outline presents a broad base which permits the evolution and continued advance in the practical education of the participating students, stimulation of the practicing physicians, and widened horizons of medical center staff participants. A concomitant medical service should assure provision for increased primary medical care for patients and future physicians for these communities.

Effectiveness of the project will depend upon the concentration of action and coordination of interest stimulated by the participants and from the public itself.

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REFERENCES

1. Medical education in transformation (Editorial): Calif Med 115:53-54, Nov 1971
2. Nicholson HC: Americans in foreign medical schools (Editorial). JAMA 217:1857, Sep 27, 1971
3. Mason HR: Foreign medical schools—Organization and expenditures in 13 schools attended by more than 2,000 US students. JAMA 217:1845-1846, Sep 27, 1971
4. The medical manpower shortage (Editorial): JAMA 217:1857-1859, Sep 27, 1971
5. Hunt GH: Medical education and American students at Guadalajara and Bologna (Congress on Medical Education). JAMA 218: 869-871, Nov. 8, 1971

No Dearth of Opportunity

To the Editor: During a nine-month period, March-November 1970, the Office for Health Manpower and Continuing Education of the Dean of the School of Medicine, University of California, San Diego, recorded brochures received through the mail announcing formal programs of conferences on various aspects of medicine for post-graduate education.

In 275 days, 211 separate offerings were received. The distribution by months was as follows: March, 39; April, 37; May, 14; June, 15; July, 8; August, 9; September, 40; October, 20; and November, 29. The conferences were distributed geographically as follows: San Diego area, 12; elsewhere in California, 30; west of the Mississippi, 66; east of the Mississippi, 96; Canada, 4; Europe, Africa and the Pacific, 1 each. The conference length was distributed as follows: 1 day, 30; 2 days, 58; 3 days, 59; 4 days, 22; 5 days, 12; 6 days and longer, 10; 17 were non-consecutive. Total conference time was 635 days, not counting travel.

Of the topics offered, 80% were primarily clinical. The most popular subject was cardiology, with 36 entries, endocrinology and metabolism were represented by 13, surgery by 11, neurology 8, cancer 8, immunology-hematology 8, pulmonary 5, and pediatric 5. Among the non-clinical topics, the most common were environmental health with 8, biochemistry with 7 and laboratory animals with 5. Sex, in one or another combination, was mentioned in only 4. And 3 were extensive medical tours.

We tried to post the notices, but quickly ran out of bulletin-board space. Our capable secretary threw in her glove, which she seldom wears.

No conclusions or morals are drawn.

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Dermatologic Radiotherapy—R.I.P.

To the Editor: Doctor Epstein's article in the November 1971 issue, "Dermatologic Radiotherapy—R.I.P.," is an example of how the inappropriate use of statistical methods can provide misleading and confusing information. This article would better be titled "Acne Radiotherapy —R.I.P." If the purpose were to obtain the opinions of the nation's dermatologists on the use of ionizing radiation in the modern practice of dermatology then the questions should have been so formulated. By limiting the inquiry to